




## Leveraging Technology to Improve Patient Flow

Today's healthcare standards have necessitated that caregivers strategically assess where improvements can be made in order to meet changing requirements and maximize efficiencies. For example, federal healthcare reform enacted in early 2010 calls for healthcare providers to deliver higher quality and safer patient care with improved customer service. For this and other reasons, healthcare organizations have begun to explore innovative measures to improve existing processes and enhance the experience for their patient populations. By exploring technological strategies to improve clinic operations, providers can also increase patient flow—ultimately resulting in the growth of net revenue.

Opened in early 2010, Pacific Medical Centers' (PacMed) Canyon Park clinic is located in Bothell, Washington. It is a recent addition to the PacMed group, a ten-clinic system that operates throughout Washington State. During the building phase, evaluation teams underwent an



**Pacific Medical Centers**  
Seattle, Washington

- Locations: 10
- Practitioners: 150

extensive research design project to identify optimal clinic layout and best practices to drive patient flow and net revenue. Through this strategic approach, PacMed identified an automated patient badge system aimed at reducing patient wait times and improving flow throughout the clinic. For insight into this innovative practice, The Academy recently spoke with Dr. Brett Daniel, Medical Director at PacMed's Canyon Park clinic.

### Taking a Patient-Centric Approach

An integral component of Canyon Park's design phase involved scrutinizing each aspect of a visit from the patient

perspective. "We had people go around to the other clinics [in the system], sit in the lobby, see what the wait times were, and determine how long it took for somebody to go door-to-door," explains Daniel. This allowed the evaluation team to establish what positively impacted the patient experience while also assessing where obstacles resided.

After an extensive assessment phase, Canyon Park identified the automated patient badge system, a real-time locating solution that ties into the practice management system at Canyon Park. "We wanted to make it as automatic as possible for

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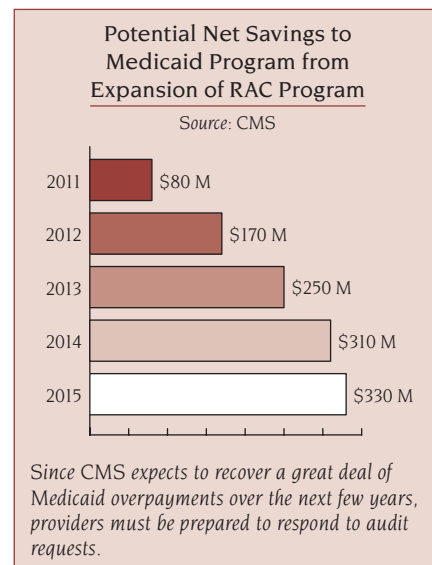
## Preparing for Payer Audits Before They Happen

In an effort to reduce improper payments, the Centers for Medicare and Medicaid Services (CMS) launched the Recovery Audit Contractor (RAC) program in 2005. Based on the success of the RAC program in recovering Medicare overpayments—approximately \$900 million during the demonstration period between 2005 and 2008—CMS created a similar audit program for Medicaid in 2009.

These audits will become an area of increasing concern for providers this year, as the federal healthcare reform bill of 2010 called on states to fully implement Medicaid RAC programs by April 2011.

The RAC audits to date have primarily focused on inpatient hospitals, with physician practices accounting for about 2% of providers audited and about \$20 million in recoveries. However, the expansion of Medicaid audits and the government's

aggressive pursuit of healthcare cost savings will increasingly encompass ambulatory care sites and group practices.



### What Auditors Are Looking For

"If physicians have never been audited and they have questions, the most proactive thing they can do is to have a baseline audit done of their documentation," says Peggy Stilley, Director of Auditing Services for AAPC Physician Services, who has over 30 years of experience working in multiple physician specialties. "That would be taking 10–15 records per physician—it doesn't need to be any more than that—and looking at their documentation."

The objective of a baseline audit is to compare clinical documentation in the sample of medical records with what has been reported to payers, and verifying that the documentation satisfies established guidelines and meets medical necessity requirements. Often, documentation shortcomings are inadvertent, resulting

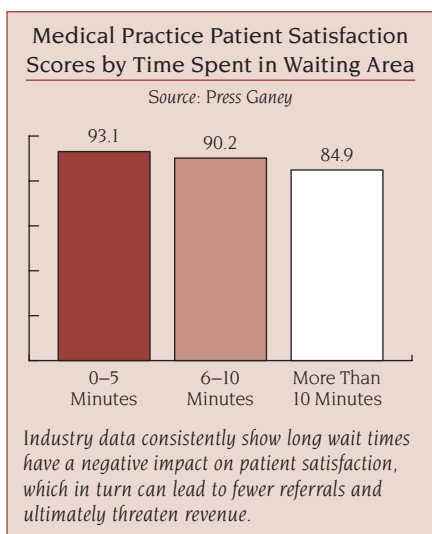
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people so they don't even know it's there," Daniel explains. Once a patient checks in at the front desk, their information is scanned into the badge, which is connected with the clinic's practice management system and they are directed towards an assigned exam room—not the waiting room.

Using infrared and radio frequency identification (RFID) technologies, a signal is sent to a computerized board every few seconds to show how far along each patient is in the appointment process. If the patient has been waiting longer than 15 minutes without any contact, an alert is sent to staff.

Canyon Park also uses the badge system to track clinic supplies and eliminate unnecessary time spent locating equipment. "We found that at some of our other



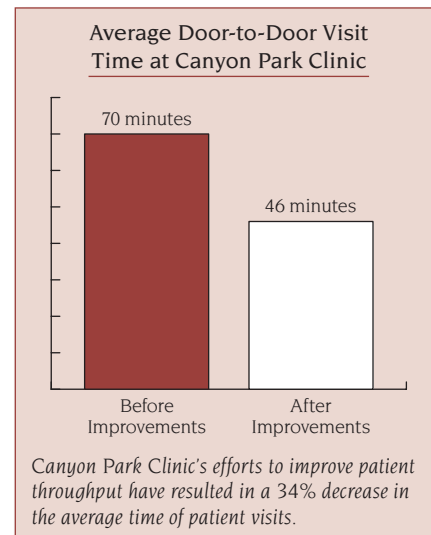
clinics, a lot of time was spent during a visit looking for supplies," explains Daniel. "We've tagged everything here so you don't waste your time going to look for things." Clinicians are able to remain in the exam room with the patient while staff responds to the automatic alert, tagging the supply inventory allows them to focus on optimal care to more patients.

**Maximizing Functional Space to Improve Operations**

By utilizing the badge system, Canyon Park was able to modify the physical layout of the clinic. Daniel explains how the badge system was essential to construction process, including a smaller waiting room, narrower hallways, additional exam rooms, and the elimination of individual physician offices. "It [the patient badge] was integral to building the clinic primarily because it became a flow tool to allow us to maximize our usable space and not waste it on waiting rooms and hallways," he says.

Because patients are not guided to their exam rooms by staff, the clinic was designed with hotel-style signage and numbering to easily direct patients throughout the clinic's hallways. Additionally, to efficiently maximize clinic space, physicians share larger workspaces rather than using individual offices.

Currently, the clinic sees approximately 350 patients a day, and has improved the total door-to-door visit time, decreasing the average from 70 minutes to about 46 total minutes. Daniel estimates patients currently wait five to ten minutes at the



most to see their doctor, while many visits fall within the 30-minute range overall. Perhaps most remarkable is the success realized involving patient satisfaction. Three months after opening, Canyon Park received the highest scores in the system—as a whole, 78% of patients rated PacMed as 'excellent', whereas Canyon Park was rated at 85%.

Daniel stresses the importance of the patient badge system to the clinic's success. "People know where things are at, we know how long people have been waiting, and it has really helped our overall patient experience," he says. By strategically shifting to patient-centric operations like the Canyon Park Clinic has, group practices can reduce wait times, see more patients, improve patient retention, and ultimately improve their bottom line.

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from the demands of physicians' daily responsibilities. Performing a baseline audit can reveal the quality of documentation, locate opportunities to capture missed revenue, and identify areas where education is needed.

Stiley says the following are some examples of auditors' inquiries that physicians must be attentive to:

**E/M Service Levels.** One focus of auditors has been scrutinizing E/M Levels 4 and 5 for medical necessity. When conducting a baseline audit, if comprehensive exams and histories are documented, it must be matched with

the level of complexity of the patient's condition.

**Bundling.** Physicians may be using modifiers to unbundle procedures when unbundling is not supported by documentation or not allowed by NCCI edits. A baseline audit can help determine whether or not services are being incorrectly unbundled.

**Documenting Time for Relevant Services.** Some services and specialties have unique audit concerns. For example, since physical therapy codes are based on time, if time is not documented the service is not billable.

Although the RACs have not substantially focused on physicians, data from the

RAC demonstration indicated the main reasons for overpayments to physicians were excessive/multiple units billed, incorrect coding of pharmaceutical injectables, and duplicate claims. If baseline audits reveal discrepancies in these areas, physicians may need to consult Chapter 17 of the Medicare Claims Processing Manual (Drugs and Biologicals) to ensure compliance with current CMS standards.

**Audit Lessons Learned from Hospitals**

In the event a physician is audited, productivity and the quality of patient care can be compromised if the practice is not prepared and has to develop an impromptu

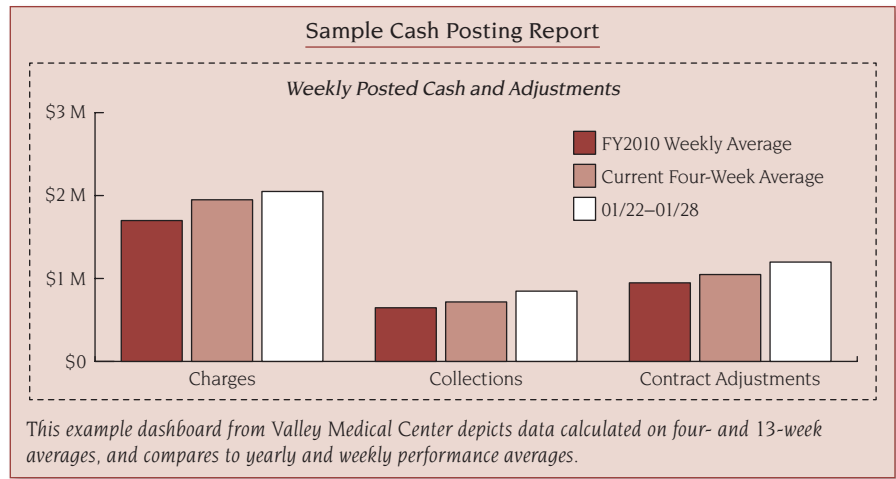
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# Integrating Metrics and KPIs into a Project Plan

While revenue cycle metrics are commonly reviewed and discussed at hospitals, many group practices place less focus on this aspect of healthcare management. However, as the healthcare industry becomes subject to increasing regulatory scrutiny, and with reductions in reimbursements from public payers a real possibility, providers in all care settings will need to ensure they are delivering the highest quality care with maximum efficiency.

Therefore, defining a set of metrics and key performance indicators (KPIs) to track performance represents a vital opportunity for clinic leaders. Creating a comprehensive reporting system to make these KPIs visible and reinforce accountability from all relevant parties fosters a culture of awareness and safeguards a healthcare organization's financial health.

To gain further insight into driving physician practice projects with metrics and KPIs, The Academy recently spoke with Shari Johnson, Director of the Physician Revenue Cycle at Valley Medical Center in Washington, about integrating reporting into routine processes and using data to guide improvement initiatives in a clinic setting. Johnson tracks and reports metrics across Valley Medical Center's network of 24 clinics; each clinic's performance is



tracked as a whole, and facilities are then benchmarked against each other to gauge relative performance and improvement opportunities.

Johnson used her previous experience in a hospital setting to create the infrastructure for tracking and reporting metrics when she started her project at Valley Medical Center. "I use the hospital's metrics as some of my baselines, because the business lines aren't [that different]—the dollars are different, the DRGs are different, but there's a lot of outpatient stuff done in the hospital that falls into the same categories," she explains. Reporting

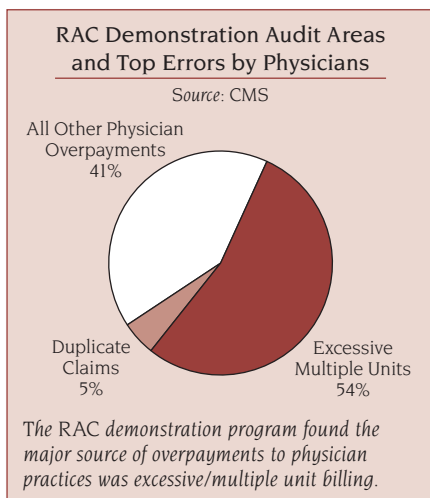
is done via a dashboard, which is posted in the room in which daily meetings are held, and distributed to management and executive teams.

Data is collected weekly, and at four and 13 weeks (quarterly) the figures are averaged. This pool of data can then be trended to reveal progress and productivity shortfalls, and indicate where to drive improvement initiatives. Additionally, reports are subdivided into three categories to reflect different service lines: specialties, urgent care, and family practice.

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response process. For this reason, it is beneficial for physicians and practice administrators to learn how hospitals have responded to RAC audits.



Last year, The Academy spoke with leaders at McLaren Regional Medical Center, a 327-bed hospital in Michigan that has experience with both RAC and private payer audits. To be able to effectively respond to audit requests, McLaren created an audit coordinator position to be the point of contact for payers, as well as a clerical position to assist the coordinator. For physician practices, it is important that the person(s) responsible for responding to auditors has the knowledge and authority to release medical records, ensuring they provide only those records the auditors are entitled to.

McLaren also had success by adopting software to facilitate their audit process. The software enabled the organization to scan audit requests into the hospital information system, and then index them into a folder by audit identification number. Medical records can then be uploaded, copied to a disc, and mailed to payers.

The McLaren compliance team is then emailed the determination, and within the system, the task of reviewing the payer's determination can be assigned to the appropriate department or individual. "If it is something clinical [staff] need to review, for example, we assign it to our clinical case management department. So, we are able to assign tasks [based on] the expertise level needed," says Director of Compliance April Scrimger.

As the prevalence of RAC and Medicaid audits increases, physicians cannot afford to assume they will avoid scrutiny without reviewing documentation processes. By performing a baseline audit of their own practice and examining the lessons learned from other providers that have been audited, physicians can ensure they are adequately prepared for any audit activity they encounter. 

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Because Johnson based her metrics on a hospital reporting system, she tracks an many different figures, which are categorized to make them most informative and useful. Main categories include:

- ☐ **POS collections:** patient responsibilities, co-pays, deposits for surgical procedures
- ☐ **Insurance verification:** secured-at-visit rate
- ☐ **Denials:** such as ineligible subscriber and authorizations missing
- ☐ **Financial counseling:** pre-service screening rate, applications pending, charity pending
- ☐ **Customer service:** call abandonment rate, average hold time
- ☐ **Bad debt**

Analyzing data has helped identify three principal improvement projects for Valley Medical Center: point of service collections, clean claims and denial management, and physician coding accuracy. “The goal really is to move everything regarding edits upstream,” Johnson says.

Point of service collections increase net revenue by ensuring that more of the patient’s liability is collected for each

**Sample Billing and Follow-Up Tracking Report**

Billing and Follow-up Work in Progress					
	Hold Invoice	Hold Balance	Non-Hold Invoice	Non-Hold Balance	Goal
\$0–\$200		\$		\$	10,000
\$201–\$500		\$		\$	2,000
\$501–\$1,000		\$		\$	0
\$1,001–\$10,000		\$		\$	0
> \$10,000		\$		\$	0
<b>Total</b>		\$		\$	<b>TBD</b>

*While the dollar ranges are much narrower in a clinic setting than at a hospital—as exemplified in the above billing and follow-up report—Johnson has found the same metric tracking system to be helpful in gauging performance and driving improvement initiatives in a group practice.*

account; Johnson says that Valley Medical Center uses a surgical estimating tool to provide estimates for patients who have scheduled outpatient surgical procedures. This enables the clinic to collect a down payment prior to or at point of service for surgical procedures as well as co-pays and self-pay responsibilities.

Clean claims have become a focus for Johnson; Valley Medical Center has purchased an electronic information reporting system that will aid in tracking clean claims data. This system will help support Johnson’s initiative to refocus her metrics from denial management to clean claims rates, emphasizing pre-billing edits and

higher accuracy rates rather than post-billing work to correct errors that go through.

The physician accuracy coding initiative is expected to help with clean claims as well. The organization tracks coding accuracy for its 164 physicians, comparing performance physician-to-physician as well as physician-to-practice patterns. Johnson examines trends and performs quarterly audits to maintain accountability and drive improvement—physicians are required to maintain a 95% coding accuracy rate. The electronic reporting system will also help improve the physician coding accuracy initiative. “For example, if a modifier’s not there we’ll be able to get back to the physician better than we are now so that they can see the pre-bill edit in a report,” Johnson says.

While instituting a culture that make revenue cycle functions a priority may seem daunting to group practice leaders, this type of data monitoring is becoming increasingly important to ensuring sound performance, maintaining accountability, and driving improvement projects. Identifying sources of leakage and error, developing action plans in response, and educating staff on the importance of revenue cycle health will help clinics drive project planning in a way that best supports their needs. ☐

**Sample Financial Counseling Tracking Report**

	1/12/2011	1/28/2011	13 Week Avg	Goal
Pre-Service Screening Rate (%)				95%
Pending DSHS (#)				–
Pending DSHS (\$)				–
Pending Charity (#)				–
Pending Charity (\$)				–
DSHS Approved (#)				–
DSHS Approved (\$)				–
Charity Approved (#)				–
Charity Approved (\$)				–

*Johnson set a 95% goal for the percent of patients financially counseled before service, then created subcategories to monitor performance details, as the above sample report shows.*



Have a success story you would like to share with The Academy and your fellow revenue cycle leaders in a future issue of *Revenue Cycle Management – Medical Group Practice Edition*? Let us know by sending an e-mail to [email@academyrcm.com](mailto:email@academyrcm.com) or calling us at 888.700.5223.